2009

# Good can become better

Summary of the 2009 Swedish Health Care Report

Socialstyrelsen

# About the 2009 Health Care Report

The Swedish National Board of Health and Welfare's descriptions and analyses of health care and medical services are aimed both at providing a picture of the state of the health-care system and at stimulating "good health and health care on equal terms for the entire population."

The ***2009 Health Care Report*** is one step in the development of a national strategy for monitoring and analysing health care and medical services. The analyses and assessments of the National Board of Health and Welfare are based on current investigations, research results and data from various registers and surveys.

In this year's report we have focused on six overall objectives for good health care – *i.e.* for care to be ***patient-centered, accessible and timely, safe, evidence-based, equitable*** and ***efficient***. These objectives or dimensions are directly linked to the Swedish Health and Medical Services Act, and can also be found in the models used by other countries to monitor and follow up health care.

In the report the National Board of Health and Welfare emphasises the importance of an increased focus on health in the health-care system in order to improve the effectiveness of health care and medical services and decrease the differences in health between various groups of the population. In addition, we have placed great emphasis on the perspective of the public and patients, as well as on the challenges facing health care in the future.

The ***2009 Health Care Report*** demonstrates many positive trends when it comes to treatment results for most major illnesses and diseases widespread in the general population, including cardiovascular diseases and diabetes. At the same time it shows that there are areas which sometimes work less well than might be wished, for example patient provision of care, accessibility and equity of care.

The aim of this summary of the 2009 Health Care Report is to provide an overview of the situation and the need for improvements within Swedish health care. At the same time we hope that it can inspire the reader to study the more comprehensive descriptions in the main report which will be available in a shortened English version in the fall of 2009.

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## Short facts about Swedish Health Care

### Regional level

Sweden is divided into 21 counties. Each county has a county administrative board, which is the Government's representative at the regional level, and a county council. County councils are responsible for ensuring that everyone living in Sweden has access to good health care. The principle of local self-government gives the county councils and regions the right to design and structure their activities with reference to local conditions. Activities are financed primarily from taxation and the county councils provide 90 percent of all care. Most of the remaining 10 percent are purchased from private companies, voluntary organisations and foundations. Private care where patients themselves pay the entire cost of their care represents a very small part of health and medical care.

### Local level

Sweden is divided into 290 municipalities. Each one has an elected council that takes decisions on a wide range of matters: schools, preschools, care of the elderly, social services, housing, roads, etc. Activities at this level are also financed primarily from taxation.

### National level

The Government governs the nation, implements the decisions of the Riksdag (parliament) and proposes new laws or amendments to legislation including health care. In order to implement laws and decisions locally and regionally it is assisted in its work by a number of governmental agencies. One of these is the National Board of Health and Welfare (NBHW), which operates under the Ministry of Health and Social Affairs. The main task for NBHW is to assist in implementing laws and decisions and evaluate quality of social welfare and health care, as well as perform inspections in these areas.

# Good health care in the future – how will it be achieved?

The report on health care is not an end in itself. The intention is to stimulate reflection and development of strategies for the future. In this introductory section the National Board of Health and Welfare summarises some of the current trends and some of the challenges facing decision- and policymakers, health care planners and professionals during the next ten-year period, and finally some possible strategies. We do not claim comprehensiveness, the purpose rather being to stimulate discussion about the future.

# Ten important trends

1 ***Public health has improved – to some extent.*** Between 1987 and 2006 the risk of suffering a heart attack decreased by 25 percent. The number of cases of cardiac insufficiency and stroke is also decreasing. The mortality rate from cancer is likewise on the decrease, despite more people being diagnosed with cancer – not least because people are living longer. More problematic is the fact that the mortality rate for chronic obstructive pulmonary disease (COPD) is increasing, as are mental health problems.

2 ***Equity is not always accomplished.*** The Swedish health-care system is generally of a high standard, compared both with the situation in previous years and with that in other countries. But there are disparities in access and quality from one county council to another and from one health-care provider to another. Several surveys have also revealed differences based on socioeconomic circumstances, in terms of access to care and medical outcomes.

3 ***An increasing number of diseases can be treated.*** During the 20th century there were significant advances in the treatment of the major diseases. Diseases which previously had a poor prognosis are now being treated, with good outcomes. There are now high expectations in the fields of molecular biology, stem-cell technology and genetic therapy. Further possibilities also arise when these methods are combined with information technology and nanotechnology.

4 ***Health care costs are increasing.*** The age distribution of the population, together with developments in medical technology, may place a great strain on health care during the coming decades. The issue of financing will probably become ever more important as the cost of health care increases.

5 ***The evidence base is being strengthened.*** Evidence as the basis for clinical decisions is being emphasised more and more. In recent years the National Board of Health and Welfare has produced several new national guidelines on good health care and revised previous ones, clarifying the recommendations regarding priorities. The new regulations and descriptions of targets for doctors' specialist training now also include a requirement for education and training in scientific methodology.

6 ***Too many patients are injured.*** Patient-safety issues have increasingly been prioritised in recent years, but significant improvements are still needed in some areas. No less than 8.6 percent of the patients in inpatient care suffered an adverse advent during 2007–2008. One in ten of these patients suffered some form of permanent injury.

7 ***Documentation is becoming more uniform.*** For many years investigations and reports have revealed deficiencies in documentation and communication concerning health care. However, the conditions for close cooperation between health-care units have now improved, including implementation of a national IT strategy for treatment and care and the adoption and application of the new Patient Data Act.

8 ***Access and waiting times remain problematic.*** Despite significant investments to deal with waiting lists, waiting times to health care remain long in many places. In the evaluation of the health-care guarantee the National Board of Health and Welfare has found that the reform has had a limited impact on waiting times, especially with regard to specialist care. 15–20 percent of patients still find it difficult or very difficult to contact primary health-care centres by phone.

9 ***Transparent comparisons improve care.*** The work on transparent reporting and comparisons of health-care outcomes has had a big impact and is increasingly being used as a basis for the work of improving health care.

10 ***Expected shortage of staff within geriatric care.*** The number of doctors and nurses has significantly increased in recent years, but the regional distribution of specialist doctors remains uneven. The labour market for nurses seems to be in a state of equilibrium. At the same time, there is a worrying trend regarding provision of staffing in municipal health care and care of the elderly.

# Nine challenges for the future

**So what can the health service do in order to attain the goal of good care on equal terms for the entire population? These are some of the challenges the National Board of Health and Welfare can see for the future:**

1 ***Decreasing the disparities in health care.*** Differences in life expectancy and morbidity between socioeconomic groups is one of the most important challenges for health care and for the welfare state as a whole. There are unexplained disparities in care and treatment among socioeconomic groups, young and old, men and women, and between people of Swedish and non-Swedish background. There are also significant differences in practice between different parts of the country.

2 ***Increasing participation of public and patients.*** Health-care legislation has strengthened the patients right to exert influence, though analyses carried out by the National Board of Health and Welfare show that health care is still operationally and professionally oriented. Information to the public must improve and patient participation in health care must be further developed.

3 ***Improving access.*** Sweden has for a long time performed poorer in measures of peoples assessments of the health care system than our neighbouring countries. It is considered that access problems greatly contribute to this. Sweden must meet the demand for planned care without renouncing access and quality of emergency care.

4 ***Develop a safety culture.*** Despite increased efforts to improve patient safety, health care remains a high-risk area. Management and control of work relating to patient safety need to be improved, research into patient safety needs to be increased and improved, and better follow-up methods need to be developed. Patients should not have to risk injury as a result of health care.

5 ***Managing the new range of diseases.*** Apart from the challenges associated with the increasing prevalence of psychiatric illness and chronic disease, as well as longer lifespans, society needs to be prepared for pandemics. Health care must have a more global focus, because of increased migration and the large numbers of tourists. This applies not only to hepatitis, HIV and tuberculosis but also to zoonosis, i.e. infectious diseases that are transmitted between animals and humans. Another concern is increasing resistance to antibiotics, which will hinder the treatment of certain infections.

6 ***Developing IT services.*** Efficient IT support is a vital part of modern health care when maintaining patient journals and in connection with various safety systems. However, more IT support needs to be developed, e.g. for decision-making and checklists and for care programmes and treatment procedures. Properly managed, IT support can more efficiently support health care processes, at the same time as communication between health care and patients improves.

7 ***Managing demographic changes.*** Sweden's population is expected to increase to almost ten million by 2020. During the same period the number of people over the age of 65 will increase by 28 percent, while the proportion of people in employment and paying taxes will decrease in relation to those not in employment.

8 ***Developing a long-term staffing plan.*** It will be increasingly difficult to provide staffing for the health-care system. It is estimated that 40,000–50,000 people a year will need to be recruited for municipal health care and geriatric care during the coming decades, i.e. nearly 500,000 people by 2020.

9 ***Resolving financing problems.*** According to some calculations the resources needed for health care will increase by approximately 20 percent by 2030, as the proportion of elderly people increase. County council tax revenues must therefore increase in the coming decades. One key political issue is how to finance increased activity using current financing structures.


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# Eight overriding strategies

**The National Board of Health and Welfare proposes eight possible strategies to meet the challenges of the next ten year period.**

1 ***Basing health care on patient needs.*** Patients need to participate more in the planning and implementation of their care and treatment. Research demonstrates that patient participation contributes to better treatment results. Patient-centered care means taking a comprehensive view of the individual and using effective, knowledge based methods in order to prevent disease and preserve people's quality of life, despite disease and disability. This strategy also include increased public and patient involvement in the prioritisation process in health care.

2 ***Increasing the emphasis on health.*** People's habits and lifestyles affect risk of suffering disease or illness. The 2009 Health Care Report shows that the health care system has achieved good results in a number of areas. At the same time, the National Board of Health and Welfare's analyses show that there is great potential to further develop the work of preventing illness and fostering health-promoting attitudes in health care. Together with increased participation of patients and their relatives, significant gains in health care can be achieved.

3 ***Following up the increased number of different care providers and freedom of choice.*** The aim of increasing freedom of choice and the number of different care providers is admirable, but there is a risk that consequences for vulnerable groups, i.e. frail elderly and people with social disadvantages, may be more negative than positive. The consequences must be carefully monitored through continuous evaluation of how the changes contribute towards addressing the legislation's aim of good health care on equal terms for the entire population.

4 ***Strengthening adherence to evidence-based guidelines at national, regional and local level.*** The effects of new pharmaceuticals and newly developed medical techniques require careful assessment in comparison with existing methods. Doctors' basic education, further training and in-service training must include skills development in the field of evidence-based medicine. Patients and the public should be able to find out about new treatment methods more easily than at present.

5 ***Increasing transparency of health care outcomes.*** Sweden needs better systems and nationally uniform models for evaluating and comparing results, based on the needs of the public, patients, the medical professions and purchasers. The system must be long-term and comprehensive. The evaluation must be independent of health care providers. Results and comparisons must be readily available to the public and patients.

6 ***Improving multi-professional collaboration and teamwork.*** The forecasts for availability of health-care staff show that a long-term plan is needed in order to meet the future demand for staff. Health-care work formats must promote flexibility and productivity, and at the same time increase quality and efficiency. Improved multi-professional teamwork and more flexible use of the staff's knowledge are both desirable and necessary.

7 ***Strengthening of safety culture in health care.*** A more advanced culture of safety is needed, along with systems for effective self-regulation, and greater knowledge and awareness about patient safety in all parts of health care and in all staff groups.

8 ***Creating new financing forms and payment models.*** There are several ways in which to deal with the expected lack of resources, for example through increased efficiency and prioritisation of what to finance publicly. In this area we can learn from experiences of other countries.

# Six important areas for good health care

How can processes, results and costs of health care be monitored? Which objectives and criterias should serve as guidelines?

These questions are top of the agenda for most health-care systems in the world. International models have inspired the development of the concept ***Good health care*** – a concept that the National Board of Health and Welfare introduced in 2005, in the regulations governing management systems for quality and patient safety in health care (SOSFS 2005:12). These regulations contain binding provisions for systematic quality assurance work – how the responsibilities are to be allocated, the areas to be covered, and the requirements for procedures for self-regulation, follow-up and feedback from experience.

One year later, in 2006, the National Board of Health and Welfare issued the guide ***Good care – about the management system for quality and patient safety in health care.*** Six quality areas for good health care are described – health care must be ***patient-centered, accessible and timely, safe, evidence-based, equitable*** and ***efficient.***

For the most part, the six areas are complementary and synergetic. At times, however, there might be tensions among them, e.g.:

- Safe care can mean that the greatest expertise must be gathered at certain locations in the country. How does this correspond to timely care?
- Efficient care can mean that a district nurse is responsible for certain treatments, but the patient may prefer to see a doctor. How does this correspond to patient-centered care?

Patient-centered

Timely

Safe

Evidence-based

Equitable

Efficient

# The patient's wishes – determining the care?

## Patient-centered care

Health care is based on respect for the equal value of all human beings, personal dignity and integrity and individuals' right to self-determination. The manner in which patients are received should be based on their personal social context, and the treatment and care should be carried out with respect for and sensitivity to individual needs, conditions, expectations and values. Health care should be planned and implemented in consultation with patients. Different treatments should be coordinated in an appropriate way, and should promote the ability to remain independent in everyday life. All of this requires dialogue between patients, health care staff and often relatives and close friends.

*"Patient-centered care means that I will be at the centre of the health-care process. This should express itself in genuine interest, not only in my particular illness but also in how it affects me as a person. Being a patient must after all mean more than just my symptoms."*

## What do we know about the current situation?

A number of different facts indicates that health care is not always as patient-centered as it should be. They include research and other studies, complaints and reports to Patients' Advisory Committees, the National Board of Health and Welfare's supervisory activities and other evidence. The possible reasons for this include the following:

- The structure, processes and follow up of health care are dominated by a function- and activity-specific approach.
- There is a lack of awareness that a patient-centered approach provides a better outcome.

Of course, there are also many positive examples of a patient-centered approach forming the basis for daily work and for quality improvement. In recent decades there has been an increasing emphasis on giving patients the opportunity to participate and exert influence – both in the field of health care policy and in the practical work of providing health care. A number of government reports have focused on how the patients' position can be strengthened, and these in turn have led to additions to health care legislation.

### Information and reception can be improved

National and regional patient surveys show that patients are partially satisfied; for example they think that health care staff are respectful. At the same time, there are areas which can be improved, for example in terms of information about the individual patient's disease and the various treatment options.

Complaints to Patients' Advisory Committees reveal frequent failings in the way patients are received, including when the reported problem concerns treatment. Between 2000 and 2007 the number of cases registered with patient boards as relating to "reception, communication, and information" increased by 41 percent – from 2,591 to 3,644 cases.

### More people seek information on the Internet

It is becoming more common for websites of county councils, patient associations and various others organisations to be used as sources of information about health care issues. For example, the county councils' collective website www.1177.se

### National measurement programme initiated in 2009

Most county councils and regions conduct their own patient or public surveys. For a long time surveys have also been conducted at national level, e.g. the Health Care Barometer and the Public Health Survey, and have included questions on reception and accessibility. As from 2009 a national patient survey is being carried out in all counties. This will enable comparison of patients' experiences at national, regional and local level.

## What needs to be improved?

- Despite the fact that the legislation clearly states the characteristics of patient-centered care, the failings include reception, information and continuity, and these factors can in turn influence safety and the results of treatment.
- Freedom of choice requires knowledge in order to offer a real choice. It is important that the information is available and easy for everyone to understand and use, so that nobody is disadvantaged in a system that rewards freedom of choice and increases the demand for self-care.
- The formats for patient participation in health care need to be developed. Many patients feel that they only participate to a limited extent in their own health care process, despite the fact that patient participation may be of great importance to safe medical care and the outcome of that care.
- There is a need for indicators and methods that measure individuals' needs and prerequisites, and how the latter are met in different care situations. Both patients and those close to them should participate in the work of developing such indicators and methods.
- Information provided for the public and communication with patients and the public about the processes and results of health care must be improved. There is a need for transparent and easily comparable reviews concerning matters such as accessibility, personal treatment, safety and outcomes of care.

# Accessible care – not just waiting times

## Timely care

Care is offered to patients, without waiting time having an adverse physical, mental or social effect on the patient. Decisions on the time-frame for the measures the patient needs are made in dialogue with the patient in accordance with parliament's prioritisation guidelines. The resources allocated to health care must correspond to the public's needs. Optimisation of the processes and procedures in the various stages of health care will increase the likelihood of all patient groups being offered care within a reasonable period of time.

*"Spontaneously, I feel that accessible and timely care within a reasonable period of time is about geographical distance, being able to get through on the phone, getting an appointment and being seen at a time convenient for me."*

## What do we know about the current situation?

Access to health care in Sweden is essentially good. Everyone who lives or permanently resides in Sweden is covered by the health care system. Most of Sweden's inhabitants have primary care facilities and pharmacies nearby and access to emergency medical services within a reasonable period of time. Health care in Sweden is mainly financed by taxes but a small fee is involved for most visits. However, only a small proportion of the population regards finance as an obstacle to seeking contact with the health care system when they need it.

The Swedish health care system has long had problems with long waiting lists, and in international comparisons Sweden is often among the worst countries. In order to shorten the waiting list a new health care guarantee was introduced in 2005, but the National Board of Health and Welfare's analyses have hitherto shown that it has only had a marginal positive influence on the waiting list.

### The health-care guarantee in brief

- Primary care will offer same-day telephone or on-site contact.
- Primary care will offer an appointment with a doctor, if needed, within a maximum of seven days.
- An appointment with a specialist will be offered within a maximum of 90 days after a decision on a referral or a request for treatment.
- The treatment decided on will be offered within a maximum of a further 90 days after the date of the decision.

### Far too many people refrain from seeking care

One in four people report that they do not have access to the care they need, and one in five do not seek treatment, despite a perceived need. More women than men refrain from seeking care despite need.

The reasons vary – some people want to wait and see, whilst others think that they cannot get any help or that seeking care is too much bother. Many people are kept on hold for too long when they ring up, or have to wait too long for primary care appointments or for specialist appointments or treatment. The proportion of those not seeking care because they cannot afford it is low (2 percent), but this nevertheless indicates that financial issues can be crucial to certain vulnerable groups

### Better information is needed

Health care providers' efforts to provide information need to be increased and improved so that patients know when and how they can expect to receive care. Information on waiting times and other accessibility aspects needs to reflect the actual situation and not on estimates.

### The health-care guarantee may sometimes be an obstacle

Many patients with neurological or neuropsychiatric injuries and illnesses find it difficult to get access to the treatment they need. This also applies to psychiatric illness, especially in the elderly, but also in children and young people. For these patients, measures on the part of different health care units, levels of care and areas of expertise must be better coordinated so as to make care more efficient and effective. The health-care guarantee can in some respects become an obstacle, as it can lead to patients having to wait several times for the same reason, instead of the care being planned, coordinated and implemented more predictably.

## What needs to be improved?

- The county councils' work on developing reliable background data in order to assess the general public's need for care needs to be developed and improved.
- There is a need for more knowledge about what the general public thinks about accessibility of care; more reliable measurement methods that measure actual waiting times should be developed.
- All county councils and health care providers should participate in reporting to the waiting time database operated by the Swedish Association of Local Authorities and Regions (SALAR).

# Towards safer care

## Safe care

Safe care is fundamental to high-quality health care, in which the treatments used lead to the expected results, without causing risks or injuries to patients. In order to prevent health care leading to adverse events, care providers must have a well-developed management system for quality and patient safety, and must actively carry out risk prevention work. This includes continuous work on setting objectives, following up, analysing and providing feedback of the results to all levels within the organisation.

*"Safe care means that there are systems in health care to ensure that one hand knows what the other hand is doing. Two different doctors should not be able to prescribe two different medications which might have a negative effect on each other!"*

## What do we know about the current situation?

All county councils and municipalities in Sweden carry out some kind of patient-safety work, though this varies in intensity and scope. The day-to-day work of health care staff, however, is rarely characterised by systematic patient safety work and a clear culture of safety. And until now, health-care providers' planning and directives for health care have mostly lacked a clear emphasis on patient safety.

### Nearly one patient in ten suffers an adverse event

According to the National Board of Health and Welfare's 2008 study of preventable adverse events, 8.6 percent of patients suffer some form of preventable adverse event in somatic hospital treatment (care of physical diseases). This means approximately 105,000 preventable adverse events and 630,000 extra care days in hospitals per year. The most common preventable adverse events are related to infections and damage to internal organs. Most injuries occur in connection with surgical procedures and medication.

Deficiencies in cooperation, management of information and communication can lead to a situation where patients are exposed to risks and preventable adverse events in care. During 2000–2006 the National Board of Health and Welfare received 1,166 complaints under lex Maria, where such deficiencies were the primary cause of a preventable adverse event. Another risk factor which can lead to poorer care and treatment, as well as to extended time in care, is the bed shortage in the country's hospitals.

### Administration of medication to the elderly entails special risks

An area which entails special risks is drug treatment of the elderly. The normal ageing process makes older persons more sensitive to medication. In addition, older persons are often prescribed many different medications. Individuals over the age of 80 receive an average of 5.7 different drugs per day, and the oldest old (89–105 years) receive 8–10 different drugs per day. This means substantial risks of side effects and of drugs having negative effects on each other.

### The focus has shifted from practitioners to the system

The health service has always been concerned about safety, but the focus has now shifted from individual practitioners to the system and the organisation. Health care staff's responsibilities remain important, but must be seen in a wider context. A management system, organisation and procedures are needed to support safe care. In many county councils and municipalities such management systems are currently under development.

## What needs to be improved?

- Care providers' management and control of the patient safety work needs to be systematically monitored.
- Every medical care provider needs a specially appointed person with overall responsibility for patient safety issues. Responsibility for the safety work must be evident in all activities.
- Much can be done to increase and improve education and research, and to change attitudes in the provision of care. For instance, patient safety research should be more integrated into traditional medical research.
- The health service needs to have structures and procedures in place for investigating all preventable adverse events occurring during or in connection with any type of care, as a matter of course. The deficiencies found must be dealt with, and systematically monitored.
- Methods for monitoring patient safety using indicators must be developed. Another way of assessing development over time is repeated and comparable studies of preventable adverse events.

# Knowledge is a process – not a condition

## Evidence-based care

Health care is based on systematically gathered, scrutinised, evaluated and compiled scientific knowledge. Reflected collective clinical experience is another basis for action. In addition, knowledge about communication with and reception of individuals is required, as well as knowledge about individual patients' understanding, wishes and expectations. Evidence-based care entails support for the health care providers in planning and transparent prioritisation when resources are allocated. To facilitate the evaluation of the appropriateness of the care, goals must be established. Patients should participate in the work of creating and spreading knowledge.

*"For me, evidence-based care means that research within health care is carried out on a continuous basis and is integrated into health care training and education. Health care staff must have advanced and proper education and training, so that I always receive the correct care."*

## What do we know about the current situation?

All the available knowledge is not always used as the basis for various decisions about health care. Some of the reasons for this are time pressure and limited awareness of the tools needed. Health care should use the methods that provide the greatest benefit based on the results of systematic research. In order for this to occur, the medical profession and decision-makers must be aware of the knowledge available and be updated about current studies.

### Good news takes precedence

The number of scientific studies is increasing. Many studies are conducted under optimum conditions, and this may result in the examined effects not being as good in clinical practice. It is also common for negative results not to be published to the same extent as positive ones. The positive effects of various treatments are therefore sometimes overstated. This emphasises the need for systematic knowledge compilations and guidelines to support health care professionals in evaluating how results should be implemented in day-to-day work.

### There is more to be done in terms of implementation

For many diseases there is a satisfactory level of knowledge and compliance with national guidelines. There is also extensive knowledge about preventive health care, but it is not implemented to the desirable extent. In this area, improvements are desired. Research shows that electronic decision-making support is the most effective way of disseminating current knowledge to health care staff. Several county councils and regions are currently developing such systems.

### Knowledge is increasing within many areas

In the 2009 Health Care Report, the National Board of Health and Welfare points to some trends regarding the development of knowledge within a number of areas relating to diagnosis:

- Knowledge about more health-gain-oriented health care has greatly increased over the past decade. Individuals who assess their health as good live longer and are less often ill than those who do not feel well. The proportion of primary health care centres with procedures and programmes for alcohol, physical activity, eating habits, smoking, stress and obesity has increased, and this type of development can also be found in hospitals. However, there is still much to be done within the field of promoting good health and preventing disease.
- Practitioners in specialist health care, e.g. in the field of cardiovascular diseases, currently have extensive knowledge, which is documented in scientific studies and national guidelines. Medical care of heart attack (myocardial infarction) has improved considerably, and the mortality rate has decreased significantly over the past 20 years. Drug treatment after a heart attack has largely been adapted to current guidelines. The prognosis for heart failure has also improved in recent years, the mortality rate having decreased by five to ten percent a year since the end of the 1980s.
- Many people today live with various chronic and complex illnesses. Team-based outpatient care has proven successful in this context. Many primary health care units have health care programmes or procedures, e.g. for diabetes, asthma and COPD. However, one study shows that only half of the health care centres caring for patients with asthma and COPD met the requirements for an approved programme, such as offering support for smoking-cessation.

## What needs to be improved?

- Recommendations need to be developed within the areas where research is not yet particularly extensive. The recommendations must be based on the best available information in the form of consensuses and proven experience, otherwise there is a risk of well-documented research fields being prioritised at the expense of other important areas.
- The production of knowledge should be coordinated in order to avoid duplication of work and contradictions. Health care providers now sometimes draw up their own recommendations instead of using national knowledge bases. When national knowledge bases are lacking, health care providers should cooperate more closely in developing knowledge bases and health care programmes.
- Designated recipients are needed locally and regionally to receive and disseminate national data and recommendations.

# Equity – different with equal rights

## Equity of care

Equity of care relates directly to the overriding objective of health care according to Section 2 of the Swedish Health and Medical Services Act: "The objective of health care is to ensure good health and care on equal terms for the entire population. Health care services must be provided with respect for the equal value of all human beings and for the personal integrity of individuals. Those with the greatest need for health care services should be given prioritised access to the care available." Health care should also be health-gain-oriented and should promote good health.

*"For me, equity of care means getting good care, irrespective of gender, origin, age or place of residence. It does not have to mean everybody receiving the same treatment for the same illness, but everybody has the right to be assessed on the basis of their particular situation and condition."*

## What do we know about the current situation?

A primary objective of Swedish health care is provision of high-quality care on equal terms, irrespective of the person receiving it. Reception, care, and treatment shall be offered on equal terms to everybody – irrespective of age, gender, sexual orientation, disability, place of residence, education, social status, country of birth or religious beliefs. Equality and equity of care are at the very heart of the Swedish Health and Medical Services Act.

Health is not distributed equally and thus a health care system should strive towards equity in health care for the entire population and it should prioritise those with the greatest need. It should also be oriented towards prevention and health promotion.

Treatment within large parts of the health care system is provided in accordance with more or less standardised care programmes and guidelines, but each patient must always receive an individual assessment, whereby care is provided on the basis of the needs in the individual case. "Equity of care" does not mean everyone getting exactly the same reception or resources – equity of care is care that the system is capable of taking into consideration the differing needs of individuals.

### People are treated differently

One question which has attracted a great deal of interest in recent years is how men and women are treated within the health service. Several studies have shown that there are systematic and significant differences in the way men and women are treated. The latest follow-ups by the National Board of Health and Welfare show that there have been some improvements in this area. On the other hand, there are differences in access to care and treatment between different socioeconomic groups and between those born in Sweden and those born abroad.

### The influence of financial situation, education and knowledge

Some people do not seek health care to the extent they ought, owing to factors such as their financial situation, level of education, knowledge and expectations. The ease or difficulty for different groups to obtain health care naturally also plays an important role.

## What needs to be improved?

- The role of health care in decreasing the disparities in health should be emphasised more. The work of the health care system in promoting health and preventing disease is crucial in this context. The health service should put its authority, its knowledge and its network of contacts to better use in order to promote health in its interaction with patients and their close relatives.
- The proportion of foreign born citizens is increasing; approximately one in five children in Sweden now have a different country of origin. The health service needs increased knowledge about how cultural differences can influence the interaction between patients and health care staff.
- Understanding and knowledge of the connections between social vulnerability and ill health are very important. There is a need for greater insight into the fact that health care can influence and decrease differences in health between different groups of the population.
- Equity of care must be monitored and analysed locally, regionally and nationally. This issue has not been given the crucial role in the monitoring of health care that could be expected in the light of the clear equality requirements laid down in the legislation. One reason for this may be is that it is difficult to monitor and follow up this area using the existing data sources.

# Value for money?

## Efficient health care

Efficient health care means optimal utilisation of the resources available in order to achieve desired goals. Efficient health care can therefore be said to have a high level of target attainment in relation to the resources utilised.

*"Efficient care means receiving the care that you need, when you need it. But it must not mean getting help within the shortest possible time, i.e. health care staff dealing with as much as possible during their working hours. Health care and services must take as long as is necessary, in order for me as patient to feel secure and satisfied."*

## What do we know about the current situation?

The health service has limited resources, and at the same time new treatment methods are being developed and expectations are increasing. This has led to ever greater interest in the efficiency of care, i.e. optimum utilisation of the resources available in order to attain set objectives.

The number of doctors has increased dramatically in recent years, but the regional distribution of specialist doctors is uneven. If the number of doctors had increased at the same rate as the population as a whole, there would have been 2,500 more doctors in 2008 than in 1998, but during this period the number of doctors actively practicing medicine increased by approximately 6,000.

In 30 years, the number of patient appointments per doctor has halved, whilst the number of doctors has tripled, according to statistics from municipalities and county councils in Sweden. This raises a number of questions about efficiency of health care, which should be more closely analysed.

### Efficient health care requires good care

With efficiency being defined as the degree to which use of resources leads to attainment of objectives, all health care objectives must be considered when following up the results of health care. This means that in order to be efficient, health care must be evidence based, safe, patient-centered, equitable accessible and timely.

There is an increasing call for health care to be efficient, but it is difficult to analyse and compare efficiency in different areas of health care or amongst different providers. The methods are still not fully developed and cost data is largely lacking, but it is clear that the highest costs are not directly correlated to the best results.

Approximately half of the costs of health care are staff-related. For this reason, staffing is an important tool for rationalising health care – partly so that health care does not utilise more resources than necessary, and partly so as to achieve the best possible results.

### One way is to redistribute the responsibilities and tasks

One way of working across professional boundaries is to redistribute roles and responsibilities, e.g. transferring certain tasks from physicians to nurses with further training. Working time can thus be released for some professional groups, improving the quality of care as a whole, though reassignment of tasks must never be at the expense of patient safety.

In recent decades interest in and awareness of the value of teamwork and so-called multidisciplinary cooperation have increased, and there are relatively good opportunities to redistribute roles and responsibilities amongst professional groups.

## What needs to be improved?

- There is a need for unified health-care processes with a cohesive approach that focus on patients' needs. There are problems between the county councils and municipalities, as well as between different units, levels and skills within the health care system.
- The forms of outpatient care probably need to be developed in order for health care as a whole to become more efficient. The health service simultaneously needs to do even more health-promotion and disease-prevention work.
- Territorial disputes between professions within health care can sometimes contribute to less efficient work instead of making the best use of the different skills available. Health care providers need to develop clear incentives to stimulate cooperation and teamwork.
- The system of individual-based cost accounting must be improved. Follow-up at individual level, unit level, health care provider level and national level is a prerequisite for analysis of effectiveness and efficiency as a whole.

# Some facts for the future

## There are more and more of us every day

The number of older people will increase faster than the number of people of working age, so fewer people will have to provide for more people.

In 2007 there were nearly 9.2 million people living in Sweden, representing an increase of 7 percent since 1990. Nearly 60 percent were in the 20–64 age range and 17 percent (approximately 1.6 million) were over 65. It is projected that Sweden's population will be 9.7 million by 2020. The proportion of people aged over 65 will then be 21 percent, i.e. 4 percentage points higher than today. The number of people over the age of 80 is also expected to increase dramatically in around 2020. The number of children and young people will increase until 2020 and the number of people of working age will increase slightly until 2014, after which the latter curve will reverse, and the number will decrease somewhat until 2020.

## Health care becomes more expensive

The total costs for health care in 2007 was SEK 278 billion. The costs increased by 13 percent between 2001 and 2007. The share the gross national product (GNP) expended for health care was 9.2 percent in 2006, which is a relative stable figure. Compared with a selection of EU countries, the Nordic countries, the United States, Canada and New Zeeland, Sweden's level is on average.

## There are more health care staff – in some locations

Access to midwives, nurses, doctors and dental hygienists increased during the period 1995–2006, while access to dentists decreased somewhat, though there are fairly big regional differences. The professional groups mentioned feature low unemployment and a high degree of establishment on the labour market after graduation.

## Organisation and management are of great interest

There is great interest within Swedish health care in the organisation and management of health care – especially as applied to health care choice models and how various payment principles and systems influence the financial driving forces and lead to production of health care. At the same time, several county councils are in the process of developing new forms of management with the assistance of process orientation, focusing on patients' progress through the health care system.

## Legislation is changing

Since 2005 a number of significant changes to legislation have been introduced, relating to patients' position in health care, organisational issues, information technology, medical ethics, psychiatry and medications.

## Some figures

- County councils are the biggest financers of health care (71 percent). Households pay 17 percent of the costs, whilst municipalities contribute 9 percent and national government 2 percent.
- Hospitals pay 45 percent of health care costs.
- Since 2001, approximately 12 percent of health care expenditure goes to medication.
- The trend is an decrease in doctor's appointments within specialist health care, whilst the number of care events in inpatient units and the number of doctor's appointments in primary care is increasing. On the other hand, the number of care days in inpatient care is decreasing.
- The number of beds in inpatient units has steadily decreased since 1992. Sweden has the fewest hospital beds per inhabitant in a comparison with many other countries.

# International comparisons

The Swedish health service can both share its knowledge with other countries and benefit from other countries' knowledge and experience. The following is a presentation of facts relating to health care outside Sweden, applying to the six categories of good health care.

## Patient-centered health care

When it comes to patient-centered health care, inspiration and experience can be gained from our neighbouring Nordic countries as well as from other countries within and outside Europe. Norway, Denmark, Great Britain and the Netherlands have great experience in terms of legislation, regulation of patient rights, work on strengthening the position of patients and national patient surveys.

Within the EU there are regular interview-based surveys involving EU citizens over the age of 15 – so-called Eurobarometers. In spring 2007 a special Eurobarometer examined people's perception of health care and care of the elderly in their respective countries. The majority of the Swedes interviewed felt that health care was of a high quality. Above all, they thought that the quality of hospital care was high; 35 percent were of the opinion that it was very good. Austria ranked highest, with 39 percent, whilst only 2 percent of those questioned in Portugal thought their health care was good.

As regards primary care, an average of 30 percent of the EU population stated that health care was very good. For Sweden, the figure was 25 percent.

## Accessibility and timely care

According to the 2008 OECD report the quality of health care in the OECD countries is improving, but it is becoming increasingly clear that preventing and dealing with chronic illness is a growing challenge for health services. In many respects, health care has essentially been based on care of acute illness, which demands short and intensive treatment. Health care activities do not score as highly when it comes to dealing with people with chronic illness who need continuous measures on the part of the health service, e.g. in the form of rehabilitation.

There are relatively few inhabitants in the EU countries who cannot get in touch with a family doctor when necessary, but there are big differences from country to country. According to the Eurobarometer, Sweden's results are amongst the poorest – nearly four in ten residents think that it is difficult to get in touch with a family doctor.

## Safe care

During the 1990s a number of national studies were conducted in the United States, Australia and New Zealand, showing that many patients suffered injuries in the course of health care. One of the first problems that was noticed was that many people suffered adverse events because of deficiencies in the handling of pharmaceuticals. These studies gave rise to the insight that there must be a shift in focus – from finding and punishing those who have made mistakes to understanding how the mistakes arose and how to prevent them from being repeated.

During the 2000s the World Health Organization (WHO) drew attention to the problem with two resolutions. They have also begun several initiatives for international cooperation, e.g. through the project World Alliance for Patient Safety.

The EU has a role in providing support and promotion when it comes to patient safety. A project has been initiated which has surveyed development within patient safety in the member states, and recommendations and terminology for the field of patient safety have been drawn up. The project has also produced an inventory of possible patient safety indicators.

## Evidence based health care

From an international perspective, it can be said that Sweden has come relatively far in terms of national knowledge bases and guidelines. Sweden is also well placed when comparing the mortality rate for the most prevalent diseases affecting the population, e.g. cardiac infarction and cancer.

In Sweden there are currently several authorities with similar responsibilities, and this can create uncertainty. A number of European countries have made structural changes to decrease the number of knowledge producers, and this has decreased the duplication of work and made the situation clearer.

## Equity of care

Internationally, it is stressed that Sweden and the other Nordic countries have come a long way in terms of equity in health care. On the other hand, it is sometimes pointed out that outpatient care in Sweden needs to be improved in order to reach groups with significant care needs.

In a comparison of "health care needs that are not met" between a number of European countries, what is particularly noteworthy about Sweden is that a high proportion of respondents state that they have not sought care because they were afraid or did not know a good doctor.

## Efficient care

In recent years there has been increased interest in the efficiency of health care in the Western world for several reasons, especially because of technological developments, ageing populations and generally increased expectations of health care. At the same time it has become clear that the countries with the highest expenditures on health care do not always achieve the best results, for example measured in terms of survival rates.

The Swedish Association of Local Authorities and Regions' report Swedish health care in an international comparison (Svensk sjukvård i internationell jämförelse) (2008) showed that Sweden achieved good medical results and average utilisation of resources, thereby putting Sweden in third place in the study. Finland was in first place. Finland admittedly had poorer medical outcomes than Sweden according to the index, but at the same time its utilisation of resources was considerably lower according to the measures used.

# Further reading

More detailed information on the areas in question can be found in the main report, ***2009 Health Care Report*** which will be available in a shortened English version in the autumn of 2009.

Other relevant reports from the Swedish National Board of Health and Welfare relating to health care in Sweden include:

- Miljöhälsorapport 2009 [Environmental Health Report 2009]
- Folkhälsorapport 2009 [Public Health Report 2009 in Swedish]
- Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet. Jämförelser mellan landsting 2008 [Quality and Efficiency in Swedish Health Care. Regional Comparisons 2008]
- Öppna jämförelser och utvärdering 2009 – HJÄRTSJUKVÅRD [This report consists of indicator-based assessment of the quality of cardiac care. It will be published in English during the autumn of 2009]

Copies of the reports may be ordered or downloaded from the National Board of Health and Welfare's website: ***www.socialstyrelsen.se***

References to more facts about health care in other countries and international comparisons between different countries' health-care system are available on WHO's website: ***www.who.int***

## Relevant WHO reports

- The World Health Report 2008: Primary Health Care – Now More than Ever
- Closing the gap in a generation

Information is also available on OECD's website: ***www.oecd.org/health/keypublications***

## Relevant OECD Report

- Health at a Glance 2007: OECD Indicators ***www.oecd.org/health/healthataglance***

## Other information

- Institute of Medicine, for example the report "Crossing the Quality Chasm" ***www.iom.edu***

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Article number: 2009-9-11

Graphic design: Informationsfabriken AB

Photographs: Blekinge Bildreportage, Hans-Peter Bloom

Printing: Edita Västra Aros, Västerås, September 2009

This summary of the 2009 Health Care Report provides an overview of the present situation and the need for improvements within the Swedish health service. Trends, challenges and overriding strategies for the coming ten years are presented in brief. Special emphasis is placed on the present situation and the need for improvements relating to the six objectives for good health care, i.e. that the care must be patient-centered, provided within a reasonable period of time, safe, based on knowledge, appropriate, made available on equal terms, and efficient. The report can also be regarded as an introduction to the main report.

Good Can Become Better – Summary of the 2009 Health Care Report
(Article Number 2009-9-11) can be ordered from the
National Board of Health and Welfare's ordering service, SE-120 88 Stockholm
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This publication can also be downloaded at www.socialstyrelsen.se

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